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Dear Attorneys Beinner, Maddox and Keyser,

Herein is the first compliance report submitted by Mohammed El-Sabaawi, M.D., and Jeffrey Geller, M.D., M.P.H. pursuant to the Settlement Agreement ("Agreement") entered into between the United States and the State of Vermont (the Agency of Human Services, the Department of Health, the Division of Mental Health and the Vermont State Hospital ("VSH")), this Agreement resolving the investigation by the United States Department of Justice ("DOJ") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. sec 1997.

Our report follows the format of the Agreement with sections of our report numbered and lettered to correspond to the Agreement. Sections generally follow the structure of findings, recommendations, and compliance indication. Recommendations are not explicitly stated when they would derive quite clearly from the findings. Data to substantiate the findings are found in the Supplements Section.

To provide examples of many of the points made, chart reviews are provided in Appendix I. To provide source material for the chart reviews, back-up documentation is provided in the Attachments. All chart reviews are referenced in the text of the report. All back-up material is references in the chart reviews.

This report represents the concurred opinion of the two experts in this case unless explicitly indicated otherwise.

DATA BASE

Documents

Vermont State Hospital (VSH) Status Report, October 16, 2006
List of all patients with all their diagnoses and the name of attending psychiatrists/physicians
Medication profiles for each patient by unit
Adverse Drug Reaction (ADR) and Medication Error or Variance (MVR) data, November 2005-September 2006
Medication Event Reporting Forms, September 7, 2006-September 25, 2006; blank ADR report
Minutes of the Pharmacy and Therapeutics Committee, February 23, 2006, April 27, 2006, August 24, 2006
Minutes of the Medical Staff Committee, December 14, 2005, February 8, 2006, April 12, 2006, May 10, 2006, June 14, 2006
Drug Utilization Evaluation (DUES) provided as Peer Review Tool for psychopharmacologic interventions, January 5, 2005-October 11, 2006
Clozapine protocol
Policy/Procedure/Protocol regarding treatment planning and any written training materials
- Interdisciplinary Treatment Plan form (current)
- Treatment Planning Policy, May 10, 2004
- Draft Treatment Planning Policy (to be presented at November Governing Body Meeting)
- Specialized Inpatient Psychiatric Services (SIPS) treatment plan draft
- Treatment Planning Meeting Structure
- Organization of Discipline-Specific Reports for Treatment Planning Meetings
- Treatment Planning Reference Manual
- Social and Independent Living Skills Modules
- Life Skills Week Long Group List – revised September 28, 2006

Policy/Procedure/Protocol regarding psychiatric assessments
- Certification Policy
- Organization of Discipline-Specific Reports for Treatment Planning Meetings

Policy/Procedure/Protocol regarding psychology services
Psychology Service Menu of Services
Policy/Procedure/Protocol regarding emergency interventions
- Current Emergency Involuntary Procedures Policy
- Draft Emergency Involuntary Procedures Policy (to be presented at November Governing Body Meeting)
- VSH Emergency Involuntary Procedures Reduction Program (EIPRP)

- Participant Manual regarding Advanced Non-Abusive Psychological and Physical Intervention (NAPPI) training
- Trainer's Manual regarding NAPPI training
- VSH written final examination and Class summary Sheet regarding NAPPI training
- List of residents that experienced seclusion and/or restraints during June to August 2006
- List of residents receiving Emergency Involuntary Medications during June to August 2006
- VSH revised Certificate of Need (CON) For Emergency Involuntary Procedure
- VSH CON For Involuntary Emergency Procedure-Post-Incident Considerations
- VSH form regarding Daily Reports of Involuntary Procedures, Constant Observations & Court ordered medications for Admissions Office

Social Services

- Staff List
- Scope of Practice
- Social Assessment form
- Social Assessment note (for admission less than three days)
- Aftercare and Discharge Planning Progress note (form and example)
- Aftercare Referral form
- PPV/SV Weekly Update form
- Notice of Discharge from PPV/SV
- Job Description, Psychiatric Social Worker, VSH
- Job Specifications, Psychiatric Social Worker, VDHR
- Job Description, VSH Social Services Chief, VSH

Policy/Procedure/Protocol regarding discharge

- Discharge Planning Policy, September 1, 2005
- Pre-placement Visit and Short Visit Policy, July 1, 2006

Psychosocial Rehabilitation materials (from groups)

- Problem Solving
- Activity Focus Group
- Communication Skills

Psychopharmacology Data

- Aggregate data on adverse drug reactions (ADR's), January 2006-present
- Aggregate data on medication variance reporting (MUR), January 2006-present
- Last ten (10) completed medication event reports on drug variances

Protection from Harm

- VSH Mandatory Reporting Policy (effective May 10, 2004) and draft revision
- Vermont Statutes Online Title 33, Chapter 69: Reports of Abuse, Neglect and Exploitation of Vulnerable Adults
- VSH database regarding incidents reported to Adult protective Services (APS) since January 1, 2006
- VSH database regarding all investigations of abuse/ neglect/ exploitation
- Database regarding resident grievances in one month (August 2006)
- VSH Employee Record Check Procedure
- VSH Database regarding patient injuries (January to September 2006)
- VSH Grievance and Appeal Policy
- VSH Patient Event Reporting Policy
- VSH Policy and Procedure regarding Disciplinary Action and Corrective Performance Action

Randomly selected sample of Patient Event Reporting Forms (July to October 2006
VSH schedule of orientation provided to new employees
VSH Restricted Items and Search policy

Incident Management

VSH database regarding patient injuries (January to September 2006)
Randomly selected sample of Patient Event Reporting Forms (July to October 2006)
VSH Governing Body Injuries and Events/Variance Reports (October 2005 to August 2006)
VSH Employee Injuries Reports and Analysis (June to August 2006)
Notes of the Employee Injury/Workplace Safety Group (June 21 and September 7, 2006)
Draft of a new "Report of Employee Event" form
VSH Patient Event reporting Policy
VSH Variance Event Reporting Protocol
VSH Mandatory Reporting Policy (effective May 10, 2004) and draft revision)
VSH Employee First Report of Injury Protocol
VSH Reporting Patient Criminal Activity to Law Enforcement Policy
VSH Risk Assessment Protocol

Publications

Fichtner C.G., et al: A self-assessment program for multidisciplinary mental health teams. *Psychiatric Services* 52:1352-1357, 2001

Interviews

Terry Rowe, Executive Director
Tom Simpatico, M.D., Medical Director
Ann Jerman, Nursing Administrator
Scott Perry, Quality Consultant
Lawrence Thompson, Ph.D., Director of Psychology
Mary Beth Bizzari, Pharmacy Director
JoEllen Swaine, Chief of Social Work
Denise McCarty, Executive Office Manager
Kathleen Daye, M.D., Primary Care Physician
Deborah Black, M.D., Neurology Services
Psychiatrists

Pam Fadness, M.D.
Sharon Satterfield, M.D.
Maria Novas-Schmidt, M.D.
Jay Batra, M.D.
John Malloy, M.D.
Richard Munson, M.D.
Robert Duncan, M.D.

Mary Hanson, Rehabilitation Services

Medical Records

Patient Charts

[redacted]

"Behavioral Treatment Plans"

IV. INTEGRATED TREATMENT PLANNING

By thirty months from the Effective Date hereof, VSH shall provide integrated, individualized protections, services, supports, and treatments (collectively "treatment") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the discipline-specific treatment planning provisions set forth below, VSH shall establish and implement standards, policies, protocols and/or practices to provide that treatment determinations are consistently coordinated by an interdisciplinary team through integrated treatment planning and embodied in a single, integrated plan.

A.* Interdisciplinary Teams

By thirty months from the Effective Date hereof, the interdisciplinary team's membership shall be dictated by the particular needs, strengths, and preferences of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:

1. Have as its primary objective the provision of individualized, integrated treatment that optimizes the patient's opportunity for recovery and ability to sustain himself/herself in the most appropriate, least restrictive setting, and supports the patient's interests of self determination and independence.

Data

See case material provided in Appendices I and II with back-up material in Attachments 1-7.

Findings

VSH is failing to consistently meet its own requirements pursuant to its own Treatment Planning Policy as follows:

- VSH clinical staff shall ensure that treatment determinations are consistently coordinated by an interdisciplinary team through integrated treatment planning and embodied in a single, integrated plan.
- The interdisciplinary team for each individual shall have as its primary objective the provision of individualized, integrated treatment that optimizes the patient's opportunity for recovery and ability to sustain him or herself in the most appropriate, least restrictive setting, and supports the patient's interests of self determination and independence; be led by a treating psychiatrist who shall assume primary responsibility for the individual's treatment; shall consist of a stable core of members, including the individual, the treating psychiatrist, registered nurse, and the social worker and, as the core team determines is clinically appropriate, other team members; meet every 30 days, and more frequently, as clinically indicated.
- Treatment plans shall provide that where possible, individuals have substantive, identifiable input into their treatment plans.
- Individuals are informed of the purposes and side effects of medication and the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented.
- Treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs.
- Treatment planning shall be based on a comprehensive case formulation for each individual that emanates from an integration of the discipline-specific assessments of the individual.

* Mislabeled "M" in the original Settlement Agreement

- Treatment planning shall be driven by individualized needs, build on an individual's current strengths, and that provide an opportunity to improve each individual's health and well being. Specifically, the treatment team shall develop and prioritize reasonable and attainable goals/objectives; provide that the goals/objectives address treatment and rehabilitation; write the objectives in behavioral and measurable terms; provide that there are interventions that relate to each objective; design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and provide that each treatment plan integrates and coordinates all selected services, supports, and treatments specifically responsive to the plan's treatment and rehabilitative goals.
- The treatment team shall revise the objectives, as appropriate, to reflect the individual's changing needs; monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes; review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors; and provide that the review process includes an assessment of progress related to discharge.

Compliance: Partial

Recommendations

- ❖ **VSH should formerly implement the "Treatment Planning Meeting Structure" – see Appendix III, Item #1.**
- ❖ **VSH should continue ongoing training in treatment planning.**

Data

See Supplement #1.

2. Be led by a treating psychiatrist who, at a minimum, shall:

   a. assume primary responsibility for the individual's treatment;

      Compliance: in compliance

   b. require that each member of the team participates appropriately in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;

      Findings

      - Initial assessment shows a wide range of quality and occasionally are absent.

- Ongoing assessment with timely revision of treatment plans inadequate.

Compliance: Partial

c. require that the treatment team functions in an interdisciplinary fashion; and

Data: See supplement #1. For example of absence of interdisciplinary process, see first Team Meeting recorded.

Findings: Not occurring on some teams, reasonably done on other.

Compliance: Partial

d. require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur in a timely fashion.

Findings: Timelines met considerably more often than not, but less than 100%.

Compliance: Partial

3. Have its composition dictated by the individual's particular needs, strengths, and preferences, but shall consist of a stable core of members, including the individual, the treating psychiatrist, nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the individual's family, guardian, advocates, and the pharmacist and other clinical staff.

Compliance: In compliance

4. Complete training on the development and implementation of interdisciplinary treatment plans to the point that integrated treatment plans meet the requirements of section IV, B, infra.

Compliance: Partial

5. Meet every 30 days, and more frequently, as clinically indicated.

Findings: Treatment teams fail to consistently meet when clinically indicated. Thresholds and indicators yet to be developed.

Compliance: Out of compliance

B. Integrated Treatment Plans

By twenty-four months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols regarding the development of treatment plans consistent with generally accepted professional standards of care, to provide that:

1. where possible, individuals have substantive, identifiable input into their treatment plans;

Findings: Substantial variation across Teams

Compliance: Partial

2. treatment planning provides timely attention to the needs of each individual, in particular:

a. initial treatment plans are completed within 24 hours of admission;

Compliance: Compliance

b. master treatment plans are completed within seven days of admission; and

Compliance: Compliance

c. treatment plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter.

Compliance: Compliance

3. individuals are informed of the purposes and side effects of medication;

Findings: Inadequate data

4. each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented, consistent with generally accepted professional standards of care; and

Data: See data in Appendices I and II, Attachments 1-7 and Supplement I.

Findings: Treatment Plans at VSH fall below just about every standard VSH has set for itself – see below.

Compliance: Out of compliance

Recommendations

- **VSH should implement the process outlined in "Organization of Discipline-Specific Reports for Treatment Planning Process (Appendix III, Item #2). The outcome should be a meaningful, individualized plan to treatment and care organized during the lines of the draft – see Appendix III, Item #3.**

Data

For examples of the current status of Treatment Plans at VSH, see Appendix I: MR # [redacted], # [redacted], # [redacted], and # [redacted].

5. treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs.

Same as Section IV.B.4.

C. By thirty months from the Effective Date hereof, VSH shall use these policies and/or protocols to provide that treatment planning is based on a comprehensive case formulation for each individual that emanates from an integration of the discipline-specific assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:

1. be derived from analyses of the information gathered from discipline-specific assessments, including diagnosis and differential diagnosis;

Same as Section IV.A,B

2. include a review of pertinent history, predisposing, precipitating and perpetuating factors, present status, and previous treatment history;

Same as Section IV.A,B

3. consider biochemical and psychosocial factors for each category in § IV.C.2 above;

Same as Section IV.A,B

4. consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;

Same as Section IV.A,B

5. enable the treatment team to reach sound determinations about each individual's treatment and habilitation needs; and

Same as Section IV.A,B

6. make preliminary determinations as to the least restrictive setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.

Same as Section IV.A,B

D. By thirty months from the Effective Date hereof, VSH shall use these policies and/or protocols to provide that treatment planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), and that it provides an opportunity to improve each individual's health and well being, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:

1. develop and prioritize reasonable and attainable goals/objectives (e.g. relevant to each individual's level of functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not to be addressed, provide a rationale for not addressing the need;

Data: See Appendix I and II, Attachments 1-7, and Supplement #1
Findings: Training has just begun in this area
Compliance: Not in compliance

2. provide that the goals/objectives address treatment (e.g. for a disease or disorder) and rehabilitation (e.g. skills/supports/quality of life activities);

Data: See Appendix I and II, Attachments 1-7, and Supplement #1
Findings: Training has just begun in this area
Compliance: Not in compliance

3. write the objectives in behavioral and measurable terms;

Data: See Appendix I and II, Attachments 1-7, and Supplement #1
Findings: Training has just begun in this area
Compliance: Not in compliance

4. provide that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her goals as specified in the objective;

Data: See Appendix I and II, Attachments 1-7, and Supplement #1
Findings: Training has just begun in this area
Compliance: Not in compliance

5. design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and

Data: See Appendix I and II, Attachments 1-7, and Supplement #1
Findings: Training has just begun in this area
Compliance: Not in compliance

6. provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through VSH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.

Data: See Appendix I and II, Attachments 1-7, and Supplement #1
Findings: Training has just begun in this area
Compliance: Not in compliance

E. By thirty months from the Effective Date hereof, VSH shall revise treatment plans as appropriate to provide that planning is outcome-driven and based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified treatment objectives, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:

Data: See Appendices I and II, Attachments 1-7, and Supplement 1.

1. revise the objectives, as appropriate, to reflect the individual's changing needs;

Findings: Compliance relevant to revision of treatment plans is dependent upon the development of adequate Master Treatment Plans. See Section IV.

Compliance: Not in compliance

2. monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;

Findings: Compliance relevant to revision of treatment plans in dependent upon the development of adequate Master Treatment Plans. See Section IV.

Compliance: Not in compliance

3. review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;

Findings: Compliance relevant to revision of treatment plans in dependent upon the development of adequate Master Treatment Plans. See Section IV.

Compliance: Not in compliance

4. provide that the review process includes an assessment of progress related to discharge; and

Findings: Compliance relevant to revision of treatment plans in dependent upon the development of adequate Master Treatment Plans. See Section IV.

Compliance: Not in compliance

5. base progress reviews and revision recommendations on data collected as specified in the treatment plan.

Findings: Compliance relevant to revision of treatment plans in dependent upon the development of adequate Master Treatment Plans. See Section IV.

Compliance: Not in compliance

V. MENTAL HEALTH ASSESSMENTS

By twenty-four months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to VSH, an

assessment of the conditions responsible for the individual's admission, and provide that it is an accurate and complete to the degree possible given the obtainable information at the time of admission. To the degree possible given the attainable information, the individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric and psychosocial factors bearing on the patient's condition, and, when necessary, for revising assessments and treatment plans in accordance with new information that comes to light. Thereafter, each individual shall receive a reassessment whenever there has been a significant change in the individual's status, a lack of expected improvement resulting from treatment clinically indicated, or six months since the previous reassessment.

A. Psychiatric Assessments and Diagnoses

1. By twenty-four months from the Effective Date hereof, VSH shall use the diagnostic protocols in the most current Diagnostics and Statistics Manual ("DSM") for reaching the most accurate psychiatric diagnoses.

Findings: Diagnoses as made in sample of cases in Attachments 1-7 used DSM-IV diagnoses

Compliance: In compliance

2. By twenty-four months from the Effective Date hereof, VSH shall ensure that all psychiatric assessments are consistent with VSH's standard diagnostic protocols.

Findings: While diagnoses use DSM-IV diagnoses (see A.1. above), psychiatric assessments do not always provide adequate justification for diagnoses, drop diagnoses without explanation, change diagnoses without rationale, or fail to resolve conflictual diagnoses in different places in the chart, e.g., contemporaneous psychiatry, psychology and social work diagnoses.

Recommendation: To be in compliance, VSH needs to correct all of the above.

Compliance: Not in compliance

3. By twenty-four months from the Effective Date hereof, VSH shall ensure that, within 24 hours of an individual's admission to VSH, the individual receives an initial psychiatric assessment, consistent with VSH's protocols.

Findings: Psychiatric Assessments were completed within 24 hours, but we were shown no VSH protocols indicating what was required in this assessment.

Compliance: Not in compliance (since protocols not yet developed)

4. By twenty-four months from the Effective Date hereof, VSH shall ensure that:

a. clinically justifiable, current assessments and diagnoses are provided for each individual;

Findings

- Initial Psychiatric Assessments do not consistently provide the basis for the diagnosis.
- Diagnoses are not consistently updated and recorded.
- Psychiatric Assessments provide little justification for evolution of diagnostic considerations.

Compliance: Partial

Data

For examples of the status of VSH's Psychiatric Assessments, see Appendix I, MR# [redacted], # [redacted], # [redacted], and # [redacted].

For examples of issues around diagnoses, see Appendix I, MR# [redacted], # [redacted], # [redacted], [redacted], and [redacted]

See Supplement #2.

b. the documented justification of the diagnoses are in accord with the criteria contained in the most current DSM;

Same as V.A.4.a.

c. differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS"("Not Otherwise Specified") are timely addressed, through clinically appropriate assessments, and resolved in a clinically justifiable manner; and

Same as V.A.4.a.

d. each individual's psychiatric assessments, diagnoses, and medications are collectively justified consistent with generally accepted professional standards of care.

Same as V.A.4.a.

5. By eighteen months from the Effective Date hereof, VSH shall develop protocols consistent with generally accepted professional standards of care to ensure an ongoing and timely reassessment of the psychiatric causes of the individual's continued hospitalization.

Compliance: Not in compliance

B. Psychological Assessments

1. By thirty months from the Effective Date hereof, VSH shall ensure that patients referred by the treating psychiatrist for psychological assessment receive that assessment, consistent with generally accepted professional standards of care, in a timely manner.

These assessments may include diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), rehabilitation and habilitation interventions, and behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.

Findings

- Psychology is not providing useful assessments.
- Psychologists are not functioning in a manner to inform other disciplines' assessments.

Compliance: Out of compliance

Data: Examples of Psychological Assessments can be found in Appendix III, Medical Record # [redacted], # [redacted], # [redacted], and # [redacted].

See Supplement #3

Recommendations: **Support and expand the recruitment and retention of neurologist, neuropsychologists, Ph.D. psychologists and behavioralists.**

2. By thirty months from the Effective Date hereof, all psychological assessments, consistent with generally accepted professional standards of care, shall:

a. expressly state the purpose(s) for which they are performed;

Same as V.B.1.

b. be based on current, accurate, and complete data;

Same as V.B.1.

c. include an accurate, complete, and up-to-date summary of the individual's relevant, clinical, and functional history and response to previous treatment;

Same as V.B.1.

d. where relevant to the consultation, include sufficient elements of behavioral assessments to determine whether behavioral supports or interventions are warranted or whether a comprehensive applied behavioral analysis and plan are required;

Findings: Only two current behavioral plans despite many patients having problematic behavior (not always disruptive), often as a result of medication refusal.

Compliance: Out of compliance

e. include determinations specifically addressing the purpose(s) of the assessment;

Same as V.B.1.

f. include a summary of the empirical basis for all conclusions, where possible; and

Same as V.B.1.

g. identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records, or re-evaluations that should be undertaken in endeavoring to resolve such issues.

Same as V.B.1.

3. By thirty months from the Effective Date hereof, previously completed psychological assessments of individuals currently at VSH shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § V.B, above. By thirty months from the Effective Date hereof, appropriate psychological assessments shall be provided in a timely manner, whenever clinically determined by the team, consistent with generally accepted professional standards of care. These may include whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment or therapeutic programming. The assessment may also be used where clinical information is otherwise insufficient and to address unresolved clinical or diagnostic questions, including "rule-out" and deferred diagnoses.

Same as V.B.1.

4. By thirty months from the Effective Date hereof, when an assessment is completed, VSH shall ensure that treating psychologists communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.

Same as V.B.1.

C. Rehabilitation Assessments

1. The treating psychiatrist shall determine and document his or her decision, prior to the initial treatment team meeting, whether a comprehensive rehabilitation assessment is required for a patient. When requested by the treating psychiatrist, or otherwise requested by the treatment team or member of the treatment team, VSH shall perform a comprehensive rehabilitation assessment, consistent with generally accepted professional standards of care and the requirements of this Agreement. Any decision not to require a rehabilitation assessment shall be documented in the patient's record and contain a brief description of the reason(s) for the decision.

Findings:

- In many charts, these assessments are not present.
- Rehabilitation Assessments are not even structured to focus on rehabilitation.

- Assessments are leisure activities, inventories, etc.

Compliance: Out of compliance

Data: Examples of Rehabilitation Assessments can be found in Appendix III, Items # [redacted], [redacted], # [redacted], # [redacted], and # [redacted].

Recommendations:

- **Establish a department/division of Psychosocial Rehabilitation.**
- **Recruit people with specific expertise in this area.**

2. By thirty months from the Effective Date hereof, all rehabilitation assessments will be consistent with generally accepted professional standards of care and shall:

a. be accurate, and coherent as to the individual's functional abilities;

Same as V.C.1.

b. identify the individual's life skills prior to, and over the course of, the mental illness or disorder;

Same as V.C.1.

c. identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and

Same as V.C.1.

d. provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.

Same as V.C.1.

3. By thirty months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at VSH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § V.C.2, above.

Compliance: Not in compliance

D. Social History Assessments

By eighteen months from the Effective Date hereof, VSH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, and explaining the rationale for the resolution offered and reliably informing the individual's treatment team about the individual's relevant social factors.

Findings: SW Assessments run the gamut from not even being in the chart (# [redacted]), to poorly done (# [redacted]) to well done (and contributing significantly to the database about the patient (# [redacted]).

Compliance: Partial

Data: For examples of SW Assessments, see Appendix III, records # [redacted], # [redacted] (absent), and # [redacted].

See Supplement #4

Recommendations

- **Consider increase in presence of Masters-prepared social workers.**
- **Conduct audits of SW's products in the medical record.**
- **Focus on decrease of duplication.**

VI. DISCHARGE PLANNING AND COMMUNITY INTEGRATION

Taking into account the limitations of court-imposed confinement, VSH shall pursue actively the appropriate discharge of individuals to the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

A.** By thirty months from the Effective Date hereof, VSH shall identify at admission and address in treatment planning the particular considerations for each individual bearing on discharge, including:

1. those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal goals;

Findings

- VSH fails to consistently follow its own Discharge Planning Policy as follows:
  - Every patient's aftercare plans shall: be created at the time of admission and updated periodically; provide specific interventions and supports designed to promote recovery in the least restrictive manner possible; and provide placements which are likely to maintain or improve the patient's level of psychosocial functioning.
  - Within three (3) days of patient's admission to Vermont State Hospital, the patient's assigned social worker will complete an Initial Social Assessment. This assessment will include a preliminary discharge plan focusing on

** Mislabeled "E" in the original Settlement Agreement

the patient's strengths and needs and setting forth recommendations for aftercare.
- Each Initial Interdisciplinary Treatment Plan shall contain a Social Service Intervention which addresses goals related to discharge planning.
- Discharge planning is a process that continues throughout a person's hospitalization. Changes in the patient's condition and circumstances may require changes to the discharge plan.
- PPV appears to have been established for the benefit of state-operated services and not for the benefit of patients.
- PPV is not even practical according to the VSH policy addressing PPV's.

Compliance: Partial compliance

Data: For record documents problematic discharge practices, see Appendix I, MR # [redacted], # [redacted], # [redacted], and Appendix II, MR # [redacted], and # [redacted].

2. the individual's symptoms of mental illness or psychiatric distress;

Same as 1 above

3. barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previously unsuccessful placements, to the extent that they are known; and

Same as 1 above

4. the skills necessary to live in a setting in which the individual may be placed.

Same as 1 above

B. By six months from the Effective Date hereof, VSH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be an active participant in the discharge planning process, as appropriate.

Findings: VSH includes patients in discussions about discharge from the time of admission. However, the use of PPV's often diminishes in a clinically significant way, the patient's "active participation" in the discharge planning process.

Compliance: Partial compliance

C. By thirty months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:

1. measurable interventions regarding his or her particular discharge considerations;

Findings: See Section IV.B. VSH continues to struggle with the "measurable" requirement.

Compliance: Partial compliance

2. the persons responsible for accomplishing the interventions; and

Same as 1 above

3. the timeframes for completion of the interventions.

Same as 1 above

D. By twenty-four months from the Effective Date hereof, when clinically indicated, VSH shall transition individuals into the community consistent with generally accepted professional standards of care. In particular, VSH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.

Findings:

See Section VD.

VSH has a cohort of Nursing Home patients who do not require state hospital level of care as follows:

- VSH has a very problematic discharge practice referred to as Pre-Placement Visits (PPV). Where the patient may safely receive psychiatric care in a less restrictive setting, such as another designated hospital or community mental health agency, the patient may be transitioned to the alternative care provider on a "pre-placement visit" ("PPV") prior to discharge. Pre-placement visits are usually two weeks in duration but may continue for up to 30 days. All patients on pre-placement visit remain patients of VSH. When a patient is on pre-placement visit, the patient's VSH treatment psychiatrist shall receive at least weekly reports/updates from the PPV care provider. If a patient is returned to VSH from PPV, the returning patient will be viewed as a new admission and treatment staff shall follow the procedures as outlined in the VSH Admissions Policy.
- PPV appears to have been established for the benefit of state-operated services and not for the benefit of patients.
- PPV is not even practical according to the VSH policy addressing PPV's.

Compliance: Out of compliance

Data

Table 1. Nursing Home Cohort as of September 12, 2006

Patient	Diagnosis(es)
Patient F	end stage Alzh/TBI
Patient L	mod-end stage Alzh
Patient O	mod stage Alzh
Patient S	BPAD and end-stage COPD
Patient K	BPAD and multiple other medical
Patient H	TBI

Recommendations

- **Discontinue the practice of PPV's.**
- **Improve discharges to Nursing Homes by making cooperatively to expand services to VSH-discharges and VSH-diversion in Nursing Homes.**
  - **Supplemental rate**
  - **Psychiatrist consultation**
- **Prioritize placements of VSH patients in all exiting and newly created residential programs.**
- **Continue the development of bridge programs.**
- **Consider expansion of UVM's psychiatry department into public sector outpatient settings.**

E. Discharge planning shall not be concluded without the referral of a resident to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the resident for the services, and the discharge of the resident.

Findings: See Section VI.D.

Compliance: Not in compliance

F. By thirty months from the Effective Date hereof, the State shall develop and implement a quality assurance/improvement system to monitor the discharge process.

Findings: Not in compliance

VII. SPECIFIC TREATMENT SERVICES

A. Psychiatric Care

By thirty months from the Effective Date hereof, VSH shall provide all of the individuals it serves adequate and appropriate routine and emergency psychiatric and mental health services consistent with generally accepted professional standards of care.

Data

Records in Appendix I as follows:

Medication Practices	MR	# [redacted]
		#
		#
		#
		#

Records in Appendix II as follows:

Medication Practices	MR	# [redacted]
Refusers		# [redacted]
		#
Consequences of Medication Refusal		# [redacted]
		#
Progress Notes		# [redacted]

Table 2. Psychiatric Medication Use (n = 54)

Polypharmacy (Two or more antipsychotics)		
	without PRN's	only with PRN's
Two atypicals	6	2
One atypical + one typical	4	2
Two atypicals + one typical	1	0
Total on two or more	11	4
PRN's		
Benzodiazepine	22	
Antipsychotic	15	
Other behavioral	2	
Benzodiazepines		
Standing order for one	9	
Standing order for two	2	
PRN	22	

Table 3. Adverse Drug Reactions

Month	No. of ADR's
November 2005	0
December 2005	1
January 2006	0
February 2006	5
March 2006	0
April 2006	2
May 2006	1
June 2006	0
July 2006	0
August 2006	0
September 2006	0

Table 4. Refusing Medications as of September 12, 2006

Patient	Date of Admission	Bed Days	Cost of Hospitalization
Patient D	5/11/06	119	$101,150
Patient A	6/26/06	84	71,400
Patient T	6/1/06	98	83,300
Patient W	5/5/05	483	410,550
Patient S	5/27/05	470	399,500
Patient N	6/16/06	84	71,400
Patient V	5/9/06	121	102,850
Patient F	7/21/06	56	47,600
Patient C	8/10/06	35	29,750
Subtotal		1,550	$1,317,500
Patient L	2003	1,000	850,000
Total		2,550	$2,167,500

By thirty months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols regarding the provision of psychiatric care consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address physician practices regarding:

a. documentation of psychiatric assessments and ongoing reassessments as per § V.A, above;

Findings

- The admission psychiatric assessments failed to include a plan of care. This is a significant departure from generally accepted standards of care. Due to this deficiency, a number of individuals

who had relatively short hospital stays were discharged from the facility without documentation of an adequate plan of care that ensured safety provided needed diagnostic clarification and directed needed treatment and rehabilitation services during their admission (e.g., # 28069 and # 28150).

- The admission psychiatric assessments are generally completed within 24 hours of hospitalization. While this practice is timely and appropriate, many of the residents are unable to provide meaningful information due to acute symptomatology at that time. This has resulted in deficiencies in the completion of mental status examination (e.g., cognitive functioning) and the integration of appropriate information from collateral sources and other disciplines. These deficiencies are generally not corrected in subsequent progress notes.

Compliance: Partial compliance

Recommendations: **Require a follow-up update of the admission assessment, as appropriate, by the seventh hospital day.**

b. documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up;

Findings

- The psychiatric reassessments, as documented in progress notes are generally focused on a cross-sectional evaluation of the individual at the time of the interaction and often fail to provide meaningful review of important developments in the individual's condition, and their context, during the previous interval.
- In too many charts, there is failure to provide timely and adequate modifications of the scheduled medication regimen even in response to adverse developments in the individual's condition, including behaviors that require the use of restrictive interventions.
- When both pharmacological and behavioral interventions are provided, there is failure to integrate treatments. There is no documentation of an exchange of data between the psychiatrist and the psychologist in order to distinguish learned behaviors from those that are targeted for pharmacological therapies and to refine diagnosis based on this exchange.
- There is failure to assess and refer residents who are refractory to current drug regimens for

electroconvulsive treatment (ECT) when clinically indicated.

Compliance: Partial compliance

c. timely and justifiable updates of diagnosis and treatment, as clinically appropriate;

Findings: Diagnoses listed as NOS are not finalized in a timely manner in some cases (e.g., # [redacted] and # [redacted]).

Compliance: Partial compliance

d. documentation of analyses of risks and benefits of chosen treatment interventions;

Findings: Documentation of analyses of risks and benefits of chosen treatment interventions are only occasionally found.

Compliance: Partial compliance

e. assessment of, and attention to, high-risk behaviors (e.g. assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;

Findings

- The ongoing assessments generally fail to track risk factors, assess contributing factors and provide timely supports and interventions to minimize the risk.
- Medication refusers are not addressed in a timely fashion; this creates unnecessary risks to other patients and staff.

Compliance: Not in compliance

Recommendation: **Address judicial delays for medication refusers.**

f. documentation of, and responses to, side effects of prescribed medications; and

Findings: Documentation of, and responses to, side effects of prescribed medications are inconsistently reported. Orders change medications without corresponding progress notes.

Compliance: Partial compliance

g. timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.

Findings

- The prescription and administration of PRN medications are generally based on generic and ill-defined indications (typically for "agitation"). Such practice lends itself to misuse of these modalities and increases the risk of use for the convenience of staff and as substitute for active treatment.
- There is almost universal failure to review the use of medications prescribed on an as needed basis (PRN) and/or STAT and to utilize the use of these medications to refine diagnosis and/or adjust regular treatment.

Compliance: Not in compliance

Recommendations

- ❖ **Review and revise PRN medication policy.**
- ❖ **Do a point-in-time study of the actual administration of PRN medication.**

2. By thirty months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address:

1. monitoring of the use of psychotropic medications to ensure that they are:

Findings

- VSH has a Pharmacy and Therapeutics Committee that provides some oversight regarding medication management. The committee does not include a dietary representative to address issues of food-drug interactions.
- At present, VSH does not have formalized systems to ensure systematic monitoring of the appropriateness, efficacy and safety of medication use.
- At present, there continues to be examples of inappropriate long-term use of high risk medications. These include:
  - General trend of PRN and Stat administration without specific justifying indications and proper review of the circumstances of use, the resident's response and the adjustment of

diagnosis and/or regular treatment, as appropriate, based on this review

- Benzodiazepine use without monitoring of effectiveness or negative impact on the residents functioning (e.g., # [redacted] and # [redacted]), including those residents who suffer from dementing illnesses (e.g., # [redacted]0)
- Anticholinergic medications without documentation of the justifying indications (e.g., # [redacted] and # [redacted])
- Antipsychotic polypharmacy without documented strategies that justify the use (e.g., # [redacted], # [redacted] and # [redacted])
- Conventional antipsychotic medications for residents suffering from tardive dyskinesia (TD) without proper monitoring and/or justification (e.g., # [redacted])

Compliance: Not in compliance

Recommendations:

- **Develop procedures that establish facility's standards regarding high-risk medication uses including PRN/STAT medications, long-term use of benzodiazepines, anticholinergic medications and antipsychotic polypharmacy and monitoring and management of residents suffering from TD. These standards must be aligned with current literature, professional practice guidelines and relevant clinical experience.**
- **Develop and implement monitoring/peer review systems to ensure compliance with facility standards once developed.**
- **Identify practitioner trends/patterns, integrate data in the current peer review system and institute educational corrective actions, as needed.**

1.1_ clinically justified;

See case #[redacted], #[redacted], #[redacted], #[redacted]

1.2_ prescribed in therapeutic amounts, as dictated by the needs of the individual patient;

See case #[redacted], #[redacted], #[redacted], #[redacted]

1.3_ tailored to each individual's clinical needs;

See case #[redacted], #[redacted], #[redacted]

1.4_ monitored for effectiveness against the objectives of the individual's treatment plan;

See case #[redacted], #[redacted]

1.5_ monitored appropriately for side effects; and

See case #[redacted], #[redacted]

1.6_ properly documented.

See case #[redacted], #[redacted], #[redacted], #[redacted]

b. monitoring of the use of PRN medications to ensure that these medications are clinically justified and administered on a time-limited basis;

Findings: See Sections VII.1.g. and VII.2.a. (mislabeled 1)

Compliance: Not in compliance

c. timely identification, reporting, data analyses, and follow up remedial action regarding adverse drug reactions reporting ("ADR");

Findings

- VSH has a data collection tool to gather information regarding ADRs.
- VSH has collected information regarding eight ADRS since January 1, 2006 (see Table 3 above).
- The current system of ADR reporting demonstrates the following deficiencies:
  - There is serious under-reporting of ADRs at VSH.
  - VSH fails to provide adequate instruction to its clinical staff regarding the proper reporting and investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for:
    - i. Classification of reporting discipline.

ii. Proper description of details of the reaction.
iii. Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc.
iv. Review of all medications that the individual was actually receiving at the time of the ADR.
v. Information about all medications that are suspected or could be suspected of causing the reaction.
vi. A rating of severity/outcome of the ADR.
vii. A probability rating, including if more than one drug is suspected of causing the ADR.
viii. Information about type of reaction (e.g., dose-related, withdrawal, idiosyncratic, allergic, etc.).
ix. Information regarding future screening.
x. Physician notification and review of the ADR.
xi. Information on the clinical review process, including the clinical review person or team, determination of need for intensive case analysis and other actions.

- VSH fails to provide a formalized system of intensive case analysis based on established ADR-related thresholds.
- VSH fails to integrate data regarding ADRs in the current system of psychiatric peer review.
- VSH fails to provide analysis of individual and group practitioner trends and patterns regarding ADRs and institute meaningful corrective and educational activities for performance improvement.

Compliance: Partial compliance

Recommendations:

- **Revise the current data collection tool and system for reporting, investigating and analyzing ADRs to address and correct all of the above-mentioned deficiencies.**
- **Train all staff.**
- **Monitor ADR reporting by Reporter. Address retraining for any discipline who appears to be failing to adequately report.**

d. drug utilization evaluation ("DUE") in accord with established, up-to-date medication guidelines;

Findings

- VSH does not have individualized medication guidelines or other systematic mechanisms that can serve as the basis for adequate DUE system.
- The only current guideline, addressing the use of clozapine, appears inadequate. This guideline does not include adequate information regarding the indications, contraindications, screening requirements, adverse effects, blood level interpretation, information regarding drug-drug interactions and interactions with diet and tobacco smoking as well as strategies for use in residents who fail to respond satisfactorily.

Compliance: Noncompliance

Recommendations

- **Develop and implement individualized psychiatric medication guidelines or some other systematic mechanisms that include appropriate information regarding indications, contraindications/precautions, adverse effects and screening thresholds/requirements. The guidelines or other documents must be derived from current literature and aligned with professional practices and relevant clinical experience. The guidelines or documents must be continually updated.**
- **Develop and implement a DUE system based on the individualized medication guidelines.**

❖ **Ensure integration of DUE data in the current peer review system and utilization of data in performance improvement activities.**

e. documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR");

Findings

- VSH collects data regarding some medication variances.
- Based on the current system, the facility reports 79 potential and 65 actual variances since January 1, 2006.
- The current MVR system is seriously inadequate due to the following deficiencies:
  - The system is focused on limited categories of variances (e.g., wrong drug, wrong resident, wrong dose and transcription variances). As a result, data provided by VSH regarding the investigation and analysis of variances since January 1, 2006 address only these categories. The failure to include other important categories (e.g., prescription, monitoring, documentation, dispensing, ordering, procurement, storage and found medications) limits the utilization of data in any meaningful performance improvement activity.
  - VSH fails to ensure that clinical staff is educated regarding the proper methods of reporting medication variances and of providing information that aid the proper investigation and analysis of the variances. The facility does not provide information or have written guidelines to staff regarding:
    i. Classification of reporting discipline.
    ii. Proper description of details of the variance.
    iii. Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.
    iv. Description of the full chain of events involving the variance.
    v. Classification of potential and actual variances.

vi. All medications involved and their classification.
vii. Information regarding critical breakdown points in the common situations that involve more than one category of variance.
viii. Adequate information regarding factors contributing to the variance.

- VSH fails to ensure a system of intensive case analysis of medication variances based on established thresholds.
- The current system is not integrated in any meaningful fashion in the activities of the P & T Committee, the MRC, the Department of Psychiatry or the Department of Medicine.
- VSH fails to collect and analyze data regarding individual and group practitioner trends and patterns in medication variances. As a result, there is no evidence of performance improvement activity based on this analysis.

Compliance: Partial compliance

Recommendations

- **Revise the current data collection tool and system for reporting, investigating and analyzing medication variances to address and correct all of the above-mentioned deficiencies.**
- **Train staff.**

f. tracking of individual and group practitioner trends;

Same as e above

g. feedback to the practitioner and educational/corrective actions in response to identified trends, when indicated; and

Findings

The deficiencies outlined in a through d above preclude meaningful assessment of this requirement at this time.

h. use of information derived from ADRs, DUE, MVR, and providing such information to the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees. By thirty months from the Effective Date hereof, VSH shall ensure that all physicians and clinicians are performing in a manner consistent with generally accepted professional standards of care, to

include appropriate medication management, treatment team functioning, and the integration of behavioral and pharmacological treatments.

Same as g above

3. By thirty months from the Effective Date hereof, VSH shall ensure that all physicians and clinicians are performing in a manner consistent with generally accepted professional standards of care, to include appropriate medication management, treatment team functioning, and the integration of behavioral and pharmacological treatments.

Findings: See section IV, VII A 1-2, B1

Compliance: Not in compliance

Recommendations

VSH's census should never exceed 54 patients unless VSH is specifically staffed for a higher census.

4. By thirty months from the Effective Date hereof, VSH shall review and ensure the appropriateness of the medication treatment, consistent with generally accepted professional standards of care.

Findings: See Section VII.A.
Compliance: Not in compliance

5. By thirty months from the Effective Date hereof, VSH shall ensure that individuals are screened and evaluated for substance abuse. For those individuals identified with a substance abuse disorder, VSH shall provide them with appropriate inpatient services consistent with their need for treatment.

Findings: Has not yet been addressed
Compliance: Not in compliance

B. Psychological Care

By thirty months from the Effective Date hereof, VSH shall provide adequate and appropriate psychological supports and services, consistent with generally accepted professional standards of care, to individuals who require such services.

Data: See Behavioral Treatment Plans for #[redacted], #[redacted], #[redacted]
See Supplement #5

For *Findings, Compliance and Recommendations* see Section 1 below

1. By thirty months from the Effective Date hereof, VSH shall ensure, consistent with generally accepted professional standards of care, adequate capacity to meet the needs of patients in the following areas of psychological services:

a. behavioral treatment;

Findings

- VSH generally fails to provide behavioral treatment for many of its residents who suffer from a variety of psychiatric symptoms and maladaptive behaviors, including, but are not limited to, aggression that at times requires restrictive interventions, s self-care and intellectual deficits and refusal of medications and other treatment and rehabilitation interventions. Many of these individuals are refractory to current pharmacological therapies and their conditions constitute appropriate targets for behavioral interventions.
- The patterns of process failures include:
  - VSH does not have sufficient staffing of trained psychologists to provide needed services
  - VSH does not have a positive behavior support system to ensure integration of this model in the day-to-day operations of the facility
  - Behavioral interventions and plans are not specified in the objectives and interventions sections of the treatment plans
  - There is no mechanism to ensure that staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and that performance improvement measures are in place for monitoring the implementation of such interventions
- The limited number of behavioral interventions that are being offered to individuals as "behavioral plans" do not comport with generally accepted standards of care and fail to meet the treatment and rehabilitation needs of individuals. A review of these plans reveals the following general patterns of deficiencies.
  - There is failure to complete functional analysis of behavior in a manner that meets professional standards. This is an essential prerequisite for effective behavioral interventions.
  - Behaviors of concern are generally not well defined, and are not measurable and observable.
  - Some maladaptive behaviors are not incorporated in the plans.
  - There is little or lack of use of direct observations of behavior.
  - Data from functional assessments is not utilized in the assessment of decreases/increases in

maladaptive/pro-social behaviors and in the designing of antecedent and consequent treatments.

- The identification of precursor behaviors is inadequate.
- There is failure to obtain data regarding precursors from appropriate sources.
- Reinforcement strategies are generally inadequate and there is no indication of a reinforcement assessment being done.
- The interventions generally do not include identification of replacement skills or means of teaching these skills. When replacement behaviors are identified, they are not functionally equivalent to the function of the maladaptive behavior.
- The interventions generally fail to include strategies to enhance the quality of life of individuals and to develop collateral social behaviors.
- There is failure to train staff on plan implementation as well as lack of monitoring of the appropriateness and consistency of implementation by the team or across situations, individuals or environments.
- There is lack of follow-up assessment of the effectiveness of behavioral interventions.
- The behavioral interventions are not integrated with either psychopharmacological therapies or the overall treatment.

Compliance: Not in compliance

Recommendations

- **VSH must ensure sufficient staffing of trained psychologists to address and correct the deficiencies outlined above. In addition, VSH needs to ensure the following:**
  - **Development and implementation of both formal behavioral plans and behavioral interventions to all individuals in need based on positive behavior support model**
  - **Identification of triggers for the institution of behavioral interventions to include excessive use of PRN and Stat medications and restrictive interventions**
  - **Ensure that all positive behavior support plans and interventions are updated as indicated by outcome data, and reported at least quarterly in**

the present status section of the case formulation in the individual's treatment plan

b. group therapy;

Findings

- Not occurring in sufficient amounts
- Not occurring in meaningful ways
- Not driven by CTP
- Not provided consistently by adequately trained personnel

Compliance: Not in compliance

Recommendations

- **Agree on need for culture shift and institute it**
- **20-hours active treatment per patient**
  - **planned**
  - **documented**
  - **outcome focused**
- **Liberman Modules, adapted for VSH**
- **Deploy unit staff to lead groups**
- **Convene meeting of Culture Transformation Committee**

c. psychological testing

Findings

- Inadequate in general
- Excellent addition of neuropsychological testing

Compliance: Not in compliance

Recommendation: **Hire psychologist on faculty of UVM.**

d. family therapy; and

Same as b

e. individual therapy

Same as b

2. By thirty months from the Effective Date hereof, VSH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are

appropriate to their individual needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.

Findings

See Section VII, Data Section.
See Section VIIB, Findings 1b,d,e, Behavioral Treatment.

3. By thirty months from the Effective Date hereof, VSH shall provide adequate active psychosocial rehabilitation, consistent with generally accepted professional standards of care, that:

a. is based on individualized assessment of patients' needs and is directed toward increasing patient ability to engage in more independent life functions;

Findings: See Section VII.B. above and Section IV

b. addresses those needs in a manner building on the individual's strengths, preferences, and interests;

Same as a

c. focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;

Same as a

d. is provided in a manner consistent with each individual's cognitive strengths and limitations;

Same as a

e. is provided in a manner that is clinically appropriate as determined by the treatment team;

Same as a

f. routinely takes place as scheduled, for those interventions that are scheduled;

Same as a

g. includes, in the evenings and weekends, additional activities that enhance the individual's quality of life;

Same as a

h. prescribes a role for the staff on the living units; and

Same as a

i. is documented in the individual's treatment plan.

Same as a

4. By thirty months from the Effective Date hereof, VSH shall ensure that:

a. behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;

Findings: See Section VB, Psychology Assessments and Section VIIB.1.a. Behavioral Treatment

b. programs are consistent for each patient within all settings at VSH;

Same as a

c. triggers for considering instituting individualized behavior treatment support plans are specified and utilized, and that these triggers include excessive use of seclusion, restraint, and emergency involuntary medication;

Same as a

d. psychotherapy, whenever prescribed, is goal-directed, individualized, and informed by a knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to psychotherapy;

Findings

- Little evidence psychotherapy provided.
- Inadequate documentation of outcomes and their relationship to outcomes in other treatment modulation.

Compliance: Not in compliance

e. psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;

Findings

- See Section VIIB, Data, Psychological Care.
- See Section VIIB. 1b,d,e.
- Nursing staff neither understand the concept of psychosocial rehabilitation nor seem prepared to learn about it.
- All clinical "staff appear befuddled" by what appears to them to be competing interest of rehabilitation and the right to refuse treatment.

Compliance: Not in compliance

Recommendations: See Section VII.B.1b,d,e

f. clinically relevant information remains readily accessible;

Findings: See Section VIII

g. all staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.

Same as a

C. Pharmacy Services

By thirty months from the Effective Date hereof, VSH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By thirty months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols that require:

1. Pharmacists to complete reviews of each individuals' medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and

Findings: Inadequate data obtained during this review.

2. Physicians to consider pharmacists' recommendations, clearly document their responses and actions taken, and for any recommendations not followed, provide an adequate clinical justification.

Same as 1

VIII. DOCUMENTATION

By thirty months from the Effective Date hereof, VSH shall ensure that an individual's records accurately reflect the individual's progress as to all treatment identified in the individual's treatment plan, consistent with generally accepted professional standards of care. By thirty months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate assessments of the individual's progress relating to treatment plans and treatment goals.

Findings

- The structure of the chart, i.e., medical chart organization, is fine.
- VSH is generally meeting the timelines for documentation in terms of assessments, treatment plans, and review, with some exceptions.
- Refused medical history and examinations are not adequately followed up.
- As indicated throughout this report, the chart's content needs considerable work.

Compliance: Partial compliance

Recommendation: **Work towards the implementation of an electronic Medical Record.**

IX. RESTRAINTS, SECLUSION AND EMERGENCY INVOLUNTARY SYCHOTROPIC MEDICATIONS

By twenty-four months from the Effective Date hereof, VSH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with generally accepted professional standards of care.

Compliance: Partial compliance

Data: See B-F below

A. By eighteen months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints and emergency involuntary psychotropic medications consistent with generally accepted professional standards of care. In particular, the policies and/or protocols shall expressly prohibit the use of mechanical restraints in a prone position and shall list the types of restraints that are acceptable for use.

Findings

- VSH has developed a draft policy and procedure that codifies the facility's expectations regarding the use of seclusion, restraints and/or involuntary medications. This draft consolidates and replaces a variety of documents governing the use of restrictive interventions, but failing to comport with generally accepted standards or provide clear guidance to staff regarding the hospital's requirements for using these procedures.
- The draft policy and procedure comports with generally accepted standards in the following key areas:
  - Requiring that all staff implementing restrictive interventions has completed competency-based training regarding the use of these interventions.
  - Requiring that seclusion and/or restraints are used in a reliable documented manner and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner.
  - Defining the role of clinical disciplines responsible for initiating, authorizing and continuing restrictive interventions.
  - Requiring adequate and ongoing monitoring by a professional during the use of seclusion and/or restraints.
  - Prohibiting the use of mechanical restraints in a prone position.

- Providing a list of the types of restrictive interventions that are acceptable for use (4-Point; 5-Point, Belt and Wristlets, Posey Vest and any use of physical force to control a resident who is restricting the administration of involuntary psychotropic medication).

- The draft policy and procedure does not include specifics regarding the competency-based training of staff in the use of restrictive and less restrictive interventions.
- VSH is yet to finalize and implement the draft policy and procedure.
- VSH has prioritized the use of seclusion and/or restraint for performance improvement. The facility has data that demonstrate decrease in the hours of restraints and seclusion as well as episodes of seclusion since August 2004. This decrease has occurred despite an increase in the average census from 45.4 in October 2005 to 51.8 in October 2006 (as of 10/17/06).

Compliance: Partial compliance

Recommendations

- **Finalize and implement the draft policy and procedure regarding the use of involuntary procedures.**
- **Ensure that the above-mentioned policy and procedure includes parameters of the competency-based training of staff in the assessment and implementation of restrictive interventions and the use of less restrictive interventions. These parameters should include the training model used and supporting literature, the method used to ensure competency and the scope and frequency of training.**
- **Continue current efforts to decrease the use of unnecessary restrictive interventions.**
- **Identify trends and patterns regarding the use of restrictive interventions and initiate interdisciplinary review and corrective actions that employ proper performance improvement methodology.**
- **Develop and implement systems that address and correct the deficiencies outlined in A through F.**

B. By eighteen months from the Effective Date hereof, and absent exigent circumstances - i.e., when a patient poses an imminent risk of injury to himself or others, VSH shall ensure that restraints and seclusion:

1. are used in a reliably documented manner and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;

Findings

- The above-mentioned draft policy and procedure adequately addresses the requirements in items B.1 through B.4.
- VSH is in the process of revising its current system of documenting the use of seclusion and restrain. The revised CON For Emergency Involuntary Procedure (draft) includes adequate definitions of seclusion and restraints, parameters for adequate documentation of the use of these interventions and an adequate outline of de-escalation measures that may have been attempted prior to involuntary measures.
- VSH has developed format for the documentation of Post-Incident Considerations. The document includes adequate information regarding needed reviews by the on-call and attending physicians as well as thresholds for notification of the Medical director and for further review by the Medical Director or designee.
- VSH is yet to finalize and implement its draft Policy and Procedure and the revised formats for documentation of seclusion and/or restraints and of the post-incident reviews.
- Review of charts indicates that, in general, VSH fails to ensure the following functions that are essential to appropriate use of restrictive interventions:
  - Adequate documentation of the restrictive intervention when more than one intervention is used sequentially (e.g. open-door seclusion followed by 5-point restraints).
  - Attending physician's review of events that signal the risk of seclusion and/or restraints and proactive modification of scheduled medication strategies to minimize the risk.
  - Timely and adequate review by the interdisciplinary team of factors that contribute to the incident.
  - Update of the interdisciplinary comprehensive case formulation following the use of seclusion and/or restraints.
  - Timely and adequate modification by the interdisciplinary team of treatment and rehabilitation interventions to address the impairments that contribute to the use of seclusion and restraints.
  - Timely and adequate implementation of behavioral

interventions to teach the resident skills that effectively replace maladaptive behaviors resulting in the use of seclusion and restraints.

- Documentation by the interdisciplinary team of the rationale for continuing the treatment plan without modification.

Compliance: Partial compliance

Recommendation: See Section A above

2. are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

Same as 1

3. are not used as part of a behavioral intervention; and

Same as 1

4. are terminated as soon as the individual is no longer an imminent danger to himself/herself or others, unless otherwise clinically indicated.

Same as 1

C. By six months from the Effective Date hereof, VSH shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints. VSH shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the monitoring of seclusion and restraints.

Finding: The above-mentioned draft Policy and Procedure meet the requirements.

Compliance: Partial compliance

D. By eighteen months from the Effective Date hereof, VSH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.

Findings

- VSH documents lists of residents experiencing the use of seclusion and/or restraints and/or involuntary medications. Review of the lists for the period of June to August 2006 indicates that the information is accurate.
- VSH has EIPRP data regarding the following:
  - Hours of restraint/seclusion, hours of restraint/seclusion per 1000 patient hours, episodes of restraint/seclusion, average hours per episode and number of residents that experienced

restraints/seclusion.

- Episodes of Emergency Involuntary Medication and number of residents experiencing this intervention.
- Hours of constant observation, episodes of constant observation and number of residents that received constant observation.

Compliance: In compliance

E. By twenty-four months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols to require the review within three business days of individuals' treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.

Findings: See Section A

F. By twenty-four months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols consistent with generally accepted professional standards of care governing the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:

1. such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;

Findings

- The draft policy and procedure adequately addresses the requirements in F.1 through F.3.
- Review of charts provides examples (# [redacted] and # [redacted]) of failure to implement the requirement regarding physician assessment of residents within one hour of the administration of emergency involuntary psychotropic medications.
- Review of charts (e.g., # [redacted]) indicates that the treatment teams sometimes fail to document an adequate review of the treatment plan and appropriate modification of treatment in response to the threshold of three administrations of involuntary medications within a four week period.

Compliance: Partial compliance

Recommendation: See Section A

2. a physician assess the patient within one hour of the administration of the emergency involuntary psychotropic medication; and

Same as 1

3. in a clinically justifiable manner, the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.

Same as 1

G. By eighteen months from the Effective Date hereof, VSH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.

Findings: See Section A

X. PROTECTION FROM HARM

By six months from the Effective Date hereof, VSH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals and require that staff investigate and report abuse or neglect of individuals in accordance with this Plan and with Vermont state statutes governing abuse and neglect as found in 33 V.S.A. § 6901, et. seq. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. VSH shall not tolerate any mandatory reporter's failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individual, VSH shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at VSH.

Findings

- VSH has a system for reporting and investigating allegations of abuse/ neglect/ exploitation of residents. The system complies with Vermont statutes governing abuse and neglect as found in 33 V.S.A. § 6901, et. seq. The main components of the facility's procedure consist of:
  - Reporting by staff to the Executive Director (within 24 hours).
  - Immediate notification by the Executive Director of APS of the Division of Licensing and protection/ Department of Aging and Disabilities.
  - Internal review by the Nursing Administrator or designee to establish circumstances and the facts of the allegation.
  - Full investigation if APS decides to open the case (depending on results of the internal review.
- The Mandatory Reporting Policy highlights staff's duty to report allegations and includes adequate definitions of abuse/neglect/ exploitation and the procedures for reporting and internally reviewing the incidents.
- Since January 2006, VSH has tracked the reporting of incidents to APS. The

tracking system includes the date and type of incident, the names of individuals involved and witnesses, location and brief description of the incident and actions taken and outcome. The database indicates that 13 incidents were reported to APS since January 1, 2006 and that only three cases have been investigated by APS to date. None of these reports resulted in substantiation of abuse, neglect and/or exploitation by staff of VSH.

- The facility has an adequate system to investigate the criminal history and other relevant background factors of potential employees to ensure that the employee would not pose a risk of harm to the residents. The system includes Vermont and nationwide and adult abuse record checks based on inquiries made to the Vermont Criminal Investigation Center and APS.
- VSH has an adequate system for processing and tracking grievances of residents.
- VSH ensures that posters regarding the abuse/neglect/exploitation and grievance systems are placed in public view of staff and residents on the units and that the information in these posters is clear and understandable.
- The current system of screening potential employees does not include provisions to ensure that volunteers, interns and consultants have received orientation to (and signified their awareness of) the facility's procedures and expectations in the area of abuse/neglect/exploitation.
- The current system of reporting and investigating abuse, neglect and exploitation demonstrates the following deficiencies:
  - The facility's definitions of exploitation do not include the unnecessary/excessive use of restrictive interventions and/or the use of more intensive services than is required by the resident's treatment plan.
  - The Mandatory Reporting Policy and Procedure does not include a clear statement that communicates zero tolerance of abuse, neglect and/or exploitation of residents.
  - The system requires staff to report incidents based on "reasonable cause to believe that any elderly or disabled adult has been abused, neglected or exploited." The obligation to report should be based on any reason to believe that abuse, neglect and/or exploitation may have occurred, including observing incidents, awareness of allegations by resident and/or staff and occurrence of frequent and/or unexplained injuries, with special attention to residents who are frail and/or have difficulty with communication.
  - The facility fails to ensure that the internal reviews of abuse/neglect/exploitation of residents are: 1) conducted only by staff members who have received competency-based training in the assessment of situations that may involve abuse, neglect and/or exploitation of residents; and 2) properly documented in appropriate formats.
  - The Mandatory Reporting Policy and procedure fails include definitions of open and closed investigations of abuse/neglect/exploitation.

- VSH does not provide adequate information that tracks the status of investigations by APS.
- There is no documentation of any mechanisms to secure the scene until a full investigation is initiated in any situation where criminal activity is alleged or seen as reasonably possible. These mechanisms should include, but not be limited to: 1) the safeguarding of evidence from potential contamination; 2) issues of exposure to blood-born pathogens; 3) securing relevant documentation; and 4) referral of residents involved in allegations of sexual abuse/rape to off-campus medical centers for proper examination.
- The Mandatory Reporting Policy and Procedure does not clearly delineate the roles of responsible authorities at the facility.
- VSH fails to ensure the protection of residents by removing staff involved in any allegation pending the outcome of the investigation. In all cases, the employee should be removed from contact with the resident until the investigation is concluded. The decision to suspend or reassign the employee should be made based on the Executive Director's assessment as to whether the allegation has merit.
- VSH was unable to provide the curriculum used in the training of staff regarding issues of abuse/neglect and exploitation. The current system does not include the facility's expectations regarding the scope and frequency of this training.
- The Mandatory Reporting Policy and Procedure does not include the expectation of disciplinary action regarding delayed reporting by staff of abuse/neglect/exploitation.
- The Mandatory Reporting Policy fails to outline mechanisms to ensure that any staff person, individual, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by VSH and/or the State.
- The current system of internal review of incidents fails to address conflict of interest issues, resident rights and employee rights.

Compliance: Partial compliance

Recommendations

- **VSH must revise its current system of reporting abuse/neglect/exploitation to address and correct all the deficiencies outlined above.**
- **VSH must develop and implement a revised policy and procedure that codifies the above expectations and that adequately addresses the**

following requirements:

- **Systematic review of all event reports and Identification of suspected abuse/neglect/exploitations and their patterns and trends.**
- **Reporting and responding to allegations.**
- **Prevention of abuse/neglect/exploitation of high risk residents.**
- **Protection of residents from suspected employees pending the outcome of the investigation.**
- **Screening of potential employees and proper orientation of volunteers, interns and consultants.**
- **Adequate process of internal investigation.**
- **Competency-based training of all staff as well as staff conducting internal investigations.**

XI. INCIDENT MANAGEMENT

By twelve months from the Effective Date hereof, VSH shall develop and implement across all settings, an integrated incident management system that is consistent with generally accepted professional standards of care.

A. By twelve months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies and/or protocols, procedures and practices shall require:

1. identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and VSH's executive director (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;

Findings

- VSH recently initiated a system for incident management with the assistance of a part-time Quality Consultant/ Manager.
- As mentioned earlier, VSH has a system for reporting allegations of abuse/neglect/exploitation. The system is codified in the Mandatory Reporting Policy. Please see findings under Protection from Harm (Section X).
- VSH has a system for reporting of Sentinel Events and Incident Events. The Patient event Reporting Policy includes adequate definitions of sentinel and incident events and outlines the reporting procedures.
- The facility has adequate database regarding incidents that result in injuries to its residents. The database includes resident names and

record numbers, unit of residence, date of injury, brief description of the nature of injury and its cause, severity rating of the injury and brief statement regarding follow-up actions. Review of the database (January to September 2006) indicates that no incident has resulted in an injury of moderate or serious nature. Review of a random sample of event reports (involving residents # [redacted], # [redacted] and # [redacted]) indicates that the information in the database was consistent with the event report.

- VSH has an adequate system for reporting employee injuries as described in the Employee First Report of injury Protocol.
- VSH has a system (Variance Event Reporting Protocol) for reporting incidents that are not addressed in the above-mentioned reporting procedures/protocols. Examples of these events include reporting of adverse drug reactions (ADR) and medication variances (MVR). Please see relevant findings under Specific Treatment Services-Psychiatric Care (Section VII.A).
- VSH has an adequate procedure to report patient criminal activity to law enforcement.
- VSH has a process for risk assessment (LOCUS rating scale) of residents upon admission, during hospitalization and at the time of discharge.
- The newly established incident management system has identified the excessive use of 1:1 observation of residents and the incidence of employee injuries as problematic patterns/trends for performance improvement. The facility is still in the process of formulating plans to address these patterns/trends utilizing performance improvement methodology. The facility's Quality Consultant/ Manager stated that process improvements, currently underway, have included documentation by physicians of the rationale for 1:1 observation of residents and draft modification of the employee reporting procedure.
- In addition to the deficiencies outlined under sections X (Protection from Harm) and VIIA (ADR reporting and MVR), the current system of incident and risk management demonstrates the following deficiencies:
  - The facility fails to ensure that the interdisciplinary teams continually assess and document the benefits and risks of different treatment and rehabilitation services in order to optimize the benefits and minimize the risks. A related deficiency concerns the team's limited or lack of review of factors that contribute to the use of seclusion, restraints and/or emergency involuntary medications.

- The current system of assessment of risk factors upon admission does not include adequate analysis of how recent the risk is relevance of the risk to dangerousness and mitigating factors.
- The current system of data collection (data collection tools and centralized database) is limited to reports of patient and employee injuries. This system is not organized to capture and provide information on various categories of high risk situations.
- At this time, VSH does not have an organized system of triggers, thresholds and high risk lists to identify situations of immediate and long-term nature requiring clinical and systemic interventions.
- VSH dose not have a system that guides staff regarding a hierarchy of interventions commensurate with the level of risk.
- There are no formalized mechanisms for notification of the clinical providers/teams regarding the need to implement specific interventions and of feedback by the providers/teams regarding the status of implementation.
- The facility does not have formalized mechanisms to monitor the timely ad appropriate implementation of interventions by providers/teams.
- VSH is yet to conduct adequate analysis of long-term trends and patterns of high-risk situations and to initiate and monitor the outcomes of corrective actions based on performance improvement methodologies. The facility's current priorities regarding the reduction of restrictive interventions, including seclusion, restraints, involuntary medications and 1:1 observation of residents are steps in the right direction.
- VSH does not have an incident/risk management oversight system that: 1) identifies patterns/trends in a timely and appropriate manner; 2) initiates performance improvement projects; 3) monitors the implementation and outcomes of corrective interventions; and 4) reports in a systematic fashion to the facility's administrative leadership. This system can be implemented as a Quality Council to include the Quality Consultant/Manager, leadership of all clinical disciplines and a representative of the environment of care.

Compliance: Partial compliance

Recommendations: See Section X

2. mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;

Same as 1

3. adequate training for all staff on recognizing and reporting incidents;

Same as 1

4. notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to VSH and State officials;

Same as 1

5. posting in each patient care unit a brief and easily understood statement of how to report incidents;

Same as 1

6. procedures for referring incidents, as appropriate, to law enforcement; and

Same as 1

7. mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action by VSH and/or the State, including but not limited to reprimands, discipline, harassment, threats or censure; except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.

Findings: Same as Section X

Compliance: Partial compliance

B. By twelve months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement policies and/or protocols to ensure the timely and thorough reporting of incidents to the Division of Licensing and Protection pursuant to 33 V.S.A. § 6901, et seq.

Findings: Same as Section X

Compliance: Partial compliance

C. By twelve months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent reoccurrence, VSH shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.

Findings: Same as A above

Compliance: Partial compliance

1. By twelve months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.

Findings

The facility maintains records of all internal reviews of abuse/neglect/exploitation allegations. The database indicates whether an investigation by APS was initiated or not, but no more information is available regarding these investigations.

Compliance: Partial compliance

2. By twelve months from the Effective Date hereof, VSH shall have a system to allow the tracking and trending of incidents and results of actions taken. Trends shall be tracked by at least the following categories:

a. type of incident;

Findings: Same as A above and Section X

Compliance: Partial compliance

b. staff involved and staff present;

Same as a

c. individuals involved and witnesses identified;

Same as a

d. location of incident;

Same as a

e. date and time of incident;

Same as a

f. cause(s) of incident; and

Same as a

g. actions taken.

Same as a

XII. QUALITY IMPROVEMENT

By thirty months from the Effective Date hereof, VSH shall develop, revise as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include substantial compliance with this Plan. The quality improvement methodologies shall be otherwise consistent with generally accepted professional quality improvement standards and shall:

A. track data, with sufficient particularity for actionable indicators and targets identified in the plan, to identify trends and outcomes being achieved.

Findings: Same as Section XI

Compliance: Partial compliance

Recommendations: Same as Section XI

B. analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:

Same as A above

1. the action steps recommended to remedy and/or prevent the reoccurrence of problems;

Same as A above

2. the anticipated outcome of each step; and

Same as A above

3. the person(s) responsible, and the time frame anticipated for each action step.

Same as A above

C. provide that corrective action plans are implemented and achieve the outcomes identified in the plan by:

1. disseminating corrective action plans to all persons responsible for their implementation;

Same as A above

2. monitoring and documenting the outcomes achieved; and

Same as A above

3. modifying corrective action plans as necessary.

Same as A above

D. utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve VSH's quality/performance goals, including identified outcomes.

Same as A above

XIII. ENVIRONMENTAL CONDITIONS

By twelve months of the Effective Date hereof, VSH shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. The system shall attempt to identify potential suicide hazards and expediently correct them. Furthermore, VSH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.

Findings

Hanging risks are both significant and substantially minimized by monitoring cameras. Staff watch the monitor. The monitor for Brooks Rehab is connected to the Brooks 1 monitor, which is observed 24/7.

Pipes under bathroom sinks, around toilets, and shower heads were enclosed
Non-recessed, non-flush mounted hard attached fixtures were replaced with recessed items
Door hinges replaced with sloping hinges
Water faucets replaced with loop-proof fixtures [are these effective?]
All screws securing vents, grates, diffusers were replaced with security screws
TV cords were encased

Compliance: Partial compliance

Data: See Supplement #6

Recommendations

- **Each patient needs a wardrobe or comparable because clothes and other possessions all over the place can be a safety hazard.**
- **Policy and Procedure for staffing of monitors.**
- **Environmental rounds by plant and clinical staff together monthly.**

ADDENDUM

Reports of this ilk generally focus on what has not yet been accomplished. In this addendum, we note Vermont's and VSH's recent progress:

- Seclusion and restraint reduction effort.
- Development of alternative community residential types.
- Employment of a cadre of psychiatrists without any dependency on a rotating cohort of psychiatrists procured through *locum tenens* companies.
- Nascent efforts in the development, in collaboration with the UVM Department of Psychiatry, of a treatment plan to be utilized at both facilities.
- Significant physical plant improvements in B-1.

- Integration of neurology and a neurologist.
- Advancements in neuropsychologist assessments.
- Nascent efforts in psychological rehabilitation, i.e., the Libermann model.
- Improved interfaces with the criminal justice system, e.g., mental health courts, DOC transfers.
- VSH-UVM collaboration on an administration-to-administration level and on a clinical level at the inpatient level of care.

If you should have any questions about this report, please feel free to contact Jeffrey Geller, M.D., M.P.H. at 508-856-6527, or via e-mail at jeffrey.geller@umassmed.edu.

Respectfully submitted,

Jeffrey Geller, M.D., M.P.H.

Mohamed El-Sabaawi, M.D.

JG/MES:vab

SUPPLEMENTS

Supplement # 1

Treatment Team – Dr. Malloy

Attendees: Psychiatrist, RN, SW, Psychologist, AT
Psychiatrist reviews case (Psychiatric Assessment).
He does a very good job of this.
Patient not at meeting at its commencement.
RN Assessments
cutting → emergency involuntary intervention times two
1:1 → 15-minute checks
nutrition → dietary consult
asthma → inhaler
SA – negative
tendency to isolate in room
SW Assessment
Spoke to case manager liaison in community.
Adds important recent history.
In community: psychiatrist, case manager, therapist (starting DBT).
Active interaction with community staff to step down to "LRA."
Patient will have to go from VSH to home since no general hospital available.
Psychiatrist goes out to get patient at 23 minutes.
Psychiatrist interviews patient, focusing on discharge. Talks about treatment goals, safety, and where she will live.
Inquires how VSH staff can help her to decrease risk of harming self.
Psychologist picks up this theme.
SW follows up.
Psychologist asks patient what has helped her in the management of self harm in the past.
Psychiatrist – We all need to develop a timeline to maximize benefits from inpatient treatment, but not to have hospitalization go on too long.
Psychiatrist explains the treatment planning process to the patient and they all attend to that.
Start with strengths:

AT:	willingness to participate in active treatment
	honest
RN:	willingness to learn to cope
	med complaint
SW:	smart
	get along well with people

Psychiatrist: discusses diagnosis
Borderline Personality Disorder
Patient: What is that?
Psychiatrist: explains in clear, layman's language. "Does this sound like you?"

Patient: "yes."
Psychiatrist: DBT targeted to persons with Borderline Personality Disorder.
Patient: "I just started it about three weeks ago."
Psychiatrist: we also need to rule out a mood disorder.
Psychiatrist: moves on to nine domains.
Everyone including patient has a work sheet with the domains listed. All Team Members have input in this process.
SW: illustrates prioritization of the problem listed under the domains.
Psychiatrist: discusses interrelationship amongst the domain problems. All Team Members (includes patient) discuss this.
Psychiatrist: "What would happen if you were discharged today?"
Patient: "I'd probably end up coming back here."
Psychiatrist: Asks patient why.
Team narrows down to small number of problems.
Team moves on to Goals for each Problem. Established Goals for (and specified)

Problem #1

- Self harm
- Involuntary emergency interventions
- Recognizing triggers (feelings)
- Communicating feelings
- What to do when get angry, e.g., increasing anger management strategies

Problem #2

- Discharge without problems

Some jumping back and forth between Goals and Interventions.
Team worked on differential between LTG and STG.
Psychiatrist references back to strengths in discussing Goals (excellent).
Psychiatrist moves on to formal discussion of interventions:
Psychiatrist says what he will do for all Goals.
SW says what she will do for all Goals.
Psychologist says what he will do for all Goals.
AT says what she will do for all Goals.
RN says what she will do for all Goals.
[The presentation and discussion was a technical error. There was no linkage of specific intervention to a specific Goal. Patient cannot know this if it is not established at the time of the development of the Comprehensive Treatment Plan].
Psychiatrist asks patient to make an explicit target date for discharge. Patient agrees to do this. Psychiatrist lobbies hard for "the end of this week." Patient reluctant to agree to this soon. Compromised with one week from today.
Psychiatrist clearly led this treatment team.

Plan to get written and then patient will be asked to sign after she reads it (excellent).
Patient left after 76 minutes of meeting (present 53 minutes).
Team writes up plan after patient leaves. Psychiatrist is the scribe. Intervention sheets are divided up amongst all the Team members for each to fill out his/her discipline page.
Process start to finish: 90+ minutes.

Treatment Team – Dr. Satterfield

#[redacted]
DOB: [redacted])
DOA: [redacted]
Patient at meeting from the outset.
No introductions. Eight staff in attendance on Team.
Psychiatrist presents history. As soon as MD says patient's name and age patient interrupts. Denies her age. Denies who she is. Patient discontinued medications January 2006. Admitted CVH May 2006 with malnutrition, electrolyte imbalance. Med ward → Psychiatric ward → VSH. Patient consistently maintains she is her half-sister and patient is dead.
Patient actively interprets with delusional material. Insists she has "bone cancer in both legs."
Psychiatrist: Dx: Schizophrenia, paranoid type, chronic.
Patient struggles to explain her past history with medication.
Medical MD: reports on Axis III diagnoses and treatments. Engages in discussion with patient. MD suggests consults, but patient says she can't go because she has no money.
Psychiatrist: Reports history of refusal of medications and groups. Involuntary medications now three weeks.
RN: Reports concerns about eating. Improved.
Patient interrupts, "They dope me."
RN continues. Concern about sleeping. RN slides right into interventions and then goals. Discusses groups. [This demonstrates the problem of making presentations by discipline rather than by problem]. She then raises urinary incontinence. Patient responds, "It is cyanide poisoning." Patient lists other poisons affecting her.
SW report. Patient has Section 8 housing. Patient not happy with Case Manager; patient wants to "Handle my own money." Patient interrupts several times during SW report.
Psychiatrist. Discuss patient's strengths. History of work as RN.
Psychologist. Move to Problems and set up Goals. States two Problems, but actually several more than this.
Goals are what to do about the Problem, psychiatrist tells patient (and staff).
Staff tell patient, "This is what I would like you to do…" "We'd like you to participate in three groups, you choose which ones."

[*Query*: How is this active treatment?]
Patient feels like there is not enough time to do what everyone is asking of her.
Psychiatrist starts talking about medication – no context. Patient pushes back – she does not want medication. Some of what patient says is delusional, some factual (although confused).
RN interrupts flow and asks patient to sign attendance sheet. She refuses.
Psychiatrist indicates need to discuss LTG's. [Why now in the flow of treatment planning?]
Patient: "I want out of Vermont. I've never been safe in Vermont." Patient shows arm and says, "Does that look like healthy tissue?" Patient and staff argue about whether it's just because she is getting old. [Staff forgot patient and staff disagree about how old she is.]
Psychiatrist again says, "What I want for you is _____."
Psychiatrist asks patient if she'll take medication. Patient replies, "I don't think I need medicine." Patient insists court process for medications was not legal.
Patient left after 48 minutes in attendance.
Psychiatrist reviews: fixed delusions, get her more involved in self-care, find her a place.
Team reviews problems.
1. Disturbed Thought Process
2. Self Care Deficit

Each of these is defined with individual characteristics.
Team review Goals. [Goals in this case are the Team's not the patient's].
Team agrees 2-3 activities/day. [Not clear why? what purpose? how related to Goals?]
Patient has now been on court ordered medications for three weeks. At maximum Prolixin dose now without good response. Psychiatrist's plan is to cross-taper to olanzapine which is allowed by court order.
Meeting lasted 55 minutes.

Treatment Team – Dr. Duncan

#[redacted]
DOB: [redacted]
DOA: [redacted]
Attendees: Psychiatrist, RN, SW, AT, Psychologist
Psychiatrist presents
Patient lives in 24-hour staff residential program, been there since age 18. Gets DD services "although technically not MR." History of abuse, state custody, child residential settings. Early testing shows low average IQ. History of multiple diagnoses, multiple medication trials. Current medications: abilify, strattera, depakote, seroquel PRN. Last VSH two years ago for three months. Now increased aggressiveness, assaults, 5:1 staff, jump from moving car. To VSH civilly.

Psychology reports on past psychometric testing. IQ shows Mild MR (IQ=65) for most valid result: (Psychiatrist – "I guess I'm wrong.") History of sex abuse and sexually abused. ADHD. Conduct disorder. Functions at 11 year 2 month level. Depression NOS. Schizoid traits. Reoffense risk. Violence is impulsive – not psychopathic. Likes: music, sports, board games, stay busy.

SW: DD bringing in additional staff in community; he can return to same apartment [What about local school system's responsibilities?]

RN: presents information about behavior on ward. No emergency interventions since admission. No depression noted. Impressionable.

Psychiatrist – notes domains to be focus of Treatment Plan.

Patient joins after 30 minutes.

Psychiatrist interviews

Asks patient about his strengths [Excellent to start with this patient with his strengths.]

Discuss struggles in the community

Discusses coping strategies in the community

Psychiatrist informs patient plan to discharge him tomorrow

Psychologist asks about school-working on GED – to accomplish GED through work [?]

SW: "did community staff visit you here?" – "yes."

Psychologist: anyone you can talk to about loss of family members? – "Yes." What is your anger management program? – "They send me to a counselor." Discussion about this: psychologist and patient.

Psychiatrist: discusses next 24-30 hours while still at VSH.

Psychiatry Fellow: makes very good point with patient about something staff could help him do.

Patient left after 20 minutes.

Impression: No treatment plan formulated because patient being discharged tomorrow. Discharge is appropriate.

Supplement # 2

Pursuant to this section of the Plan (and others) VSH has retained Deborah Black, M.D. a Neurologist. Previously part-time for five years, Dr. Black is now .8 FTE (4 days/week). She is employed by UVM with a dual appointment: Neurology and Psychiatry. Her specialty is Behavioral Neurology. She provides consults for Attending Psychiatrist. These are oral and written with a written consult produced by Dr. Black and found in consult section.

Difficulties doing Neurology consults at VSH are the interpretation of neurology input into both the Team process and the, care of patient. Getting diagnostic tests not a problem; they come back in timely way. Generally done at CVH.

Transfer from VSH to a medical hospital are most often due to seizures, fall → concussion, and dilantin toxicity.

Dr. Black follows some patient as a consultant – those who have primary neurological disorders. VSH is considering making Dr. Black the Attending Physician for some of these cases.

Dr. Black indicated there is clear accord between Medical MD and Neurologist about criteria for Neurology consult. These are often for MR with questions of differential diagnosis and/or the need to be at VSH; and for cognitive disorders such as dementia or developmental disorders.

Supplement # 3

Larry Thompson, Ph.D., Director of Psychology, provides the following overview of the Department.

Referral Service

2 FTE: 1 Ph.D.
1 MA

1 Consultant: 1 Ph.D.
as needed (about 1.5-2 days/week)

Transition year
From Team Members to consult service

Initial Psychology Assessment
Was never at 100%
Selected cases
Diagnostic question
Forensic referral
Patient looks different than earlier admission

Behavioral Plan
Sequence:

1. Request from Psychiatrist
2. Psychology meets with Treatment Team and ward staff
3. Baseline data collection by ward staff
4. Explore possible reinforcers
5. Draft of plan
6. Staff reviews draft
7. Final plan
8. Plan put into effect
9. Unit staff responsible for plan
10. Training is "informal" by psychologist
11. Data sheets daily by ward staff
12. Psychologist collects sheets daily and maintains graph
13. Presents graph to Treatment Team

Currently two Behavioral Plans

Brooks 2. Highly varied behaviors, paranoid, loud outburst, pounding on office windows, long hospitalization. Reinforcers are money and trips off ward.

Brooks 1. Manic state, loud, yelling at staff, in-out of other patient rooms, taking other patients' possessions, urinating on floor, destroying floor tiles. Reinforcer is use of walkman.

Disruptive behavior generates requests for plans.

Supplement # 4

An overview of Social Services indicates that discharge planning starts at admission. The SW meets with patient within 72 hours of admission. Social Histories are obtained. The SW contributes to the admission database, and collects collateral contacts. He/she would contact family members, case managers, and others.

Barriers (besides clinical) to being an effective social services at VSH per Director of SW include patients' legal charges and lack of availability of appropriate placement settings.

> Director of SW opines there are about three types of patients at VSH simply because there is no appropriate setting for them, such as: 1) sex offender/violence, 2) Alzheimer's, and 3) TBI.

There are Community-Based Case Managers and a majority of patients at VSH have Case Managers. It is rare for a Case Manager to come to a VSH Treatment Team. They are available through at least weekly phone contact.

SW's participation with patients include: 1:1 SW meetings, Treatment Plan development, Treatment Plan reviews.

Some VSH patients are discharged to another hospital as a "step down" to a less restrictive setting. These are voluntary placements. The patient's status is preplacement visit (short visit). Patients on this status are technically a VSH patient. The two different hospital treatment teams talk every week. The VSH attending psychiatrist maintains (legal) responsibility.

Supplement # 5

Patient Engagement/Rehabilitation

Brooks 2, 11:20 a.m. (Male and female admitting)

20 patients
4 RN (+ 1 orientee) (+1 charge RN)
11 Techs
7 1:1's
All patients on ward
Goals group on ward – 13 patients
Basement Group (Individual Skills – "They work on what they want to")* - 6 patients
OT – 1 patient; Walk – 1 patient (both of these were also in Basement Group)
Discussion Group (on ward) – 3 patients

*another staff said Basement Group runs as a function of individual needs – AT staff same in Basement as on Team. Limit 5-6 per staff from a ward.

1:1's

1. Eating/sleeping (chocking, apnea)
2. High suicide risk
3. Violence towards others
4. Self harm
5. Self harm/suicide risk
6. Self harm/violence to others/manic
7. High suicide risk

Of the seven, one refusing medication.

Brooks 1 (female admission)

18 patients
3 RN's
1 LPN
8 Techs
one 1:1 (for confusion)
Canteen – 2
Goals Group (on ward, lasts 10 minutes) – 6 patients
Individual Skills (Basement Group) – 4 patients (3 of 4 patients in both Individual Skills and Goals Group)
Work – 1 patient (also in Goals Group)
Dual Diagnosis – 1
Therefore, 11 patients had no active treatment at all.
Of those with active treatment:
One patient 40'
One patient 60'
Three patients 70'
One patient 130'

Rooms are locked from 8:30 a.m. – 10:30 a.m., TV off
5/12 patients refusing medication
10:00 a.m. Yard open
Patient can sleep in dayroom
New patients can stay in their rooms until they get acclimated to the rules (couple of days)
Smoking (on smoking porch or yard)

1-2 cigarettes	5:15 a.m.
1 cigarette	7:00 a.m.
1-2 cigarettes	8:00 a.m.
1-2 cigarettes	10:00 a.m.
1-2 cigarettes	12 noon
1-2 cigarettes	1:00 p.m.
1-2 cigarettes	3:00 p.m.
1-2 cigarettes	5:00 p.m.
1-2 cigarettes	7:00 p.m.
1-2 cigarettes	9:00 p.m.
1-2 cigarettes	10:00 p.m.

Total 21 cigarettes/day
Staff holds cigarettes
VSH employee purchases cigarettes by taking off campus "cigarette shopping trips"

OT Group, 2:13 p.m. – (Dale 2)
3 patients
1 COTA
1 patient working, 1 rocking in rocking chair, 1 studying construction management through correspondence course
"only 3 referred"

Individual Skills, 2:23 p.m. (Basement)
8 patients
4 staff (COTA, 2 AT's, 1 Tech)
Patient chooses what he/she wants to do
Staff is (according to them):
doing assessments
encouraging social skills
stress reduction
COTA – does not know any patient's short-term goal. "I know generally what my patients need."
Patients here 30-60 minutes

Patients are scanned at end of group. All patients scanned every time they leave the unit before they go back on to the unit.

Brooks Rehab Unit, 2:36 p.m.
13 patients
3 RN's (1 charge, 1 med, 1 treatment)
5 Techs
One on 1:1 (Alzheimer's, unsteady, falls, combative, disposition problem).

Goals Group** – 10 patients
10-15 minutes
Positive Thinking Group – 3 patients
Off unit to Canteen** – 8 patients
Individual Skills Group (AM) – 4 patients
*Green Book – activities for patients – 3 patients
*Walk on grounds – 2 patients
Individual Skills Group (PM) – 2
OT – 2 patients
Counseling session – 1 patient
2/13 went to no groups at all

* Not in Individual Treatment Plan
** May or may not be in Individual Treatment Plan

Per unit staff, 8/13 do not need hospital level care and could leave if placement available (includes forensic patients)
This evening, patients will have (scheduled):
Current Events Group
Goals Wrap-Up
Library Group
Walk
Patients may *choose* the group; none of these are OT groups; all led by unit staff

Smoking Policy
Some patients restricted
Some patients carry own cigarettes
Smoke about every 2 hours
7:00 a.m. – 11:00 p.m.
This is about 1 pack per day at 2 cigarettes per smoking time
Patient bedrooms routinely locked 8:30 a.m. – 10:00 a.m.
Patients can sleep in dayroom undisturbed by staff (says the RN). Can push two chairs together to sleep. Discouraged from sleeping on the floor.

Liberman Module: Leisure Skills, 1:30 p.m. (Brooks Rehab)
Group actually started 1:40 p.m.
Group title: Recreation for Leisure
6 patients
2 staff
Introductions
Completion of overview of what the group will be about. Continues agenda started at meeting one week ago. Handout: "Problem Solving."
Activity Focus Groups handout
Communication Skills handout
Technique: Role Playing

Impression: Well done group.
Query: How is this intervention fed back into each participants' CTP?

B3 Rehabilitation

- Organization
  - 5 Activity Therapists
    - 3 COTA
    - 2 AT (one BA, one with 28 years experience)
  - OT consultant 24 hours/2 weeks
    - State retiree
  - Vacant Chief of Therapeutic Services (currently under recruitment)
    - (AT & OT)
  - Currently 5 AT's answer to Director of Psychology
- Current Task
  - Roll out of Liberman Psychosocial Skills Modules
- Assignment
  - Each ward has at least one AT
    - Brook 1 – 2
    - Brook 2 – 2
    - Brook Rehab – 1
  - AT goes to Treatment Team of their patient, so goes to multiple Treatment Teams on ward
  - Activity Therapy Assessment – done by assigned AT, should be 100%. Also reassessment every three months.
  - AT does treatment on his/her own patients
  - Groups that draw from all wards are limited to:
    - Liberman Modules
    - OT
    - Wellness Recovery
    - SA
    - Cooking group x 2
    - Others like walks
    - [Individual Skills]
- Getting Patients to Group
  - "Ongoing issue"
  - "Treatment resistant patients"
- Groups often not attached to Treatment Plan
  - Especially true of on ward groups, ward staff lead groups

Supplement # 6

B1

Dayroom — institutional appearance
institutional furniture
blind spots from nursing station

Bedroom — singles, toilet/sink combo in bedroom
No storage at all so patients use the floor
Rooms appear leftover from maximum security days

Smoking porch – stinks, it's a cage

Bathroom – no ventilation, mold, sharp plaster in toilet paper holder

Seclusion room – DOOR OPEN
This practice of unstaffed, unlocked seclusion door must stop.

Hallway — doors and locks to bedrooms left from maximum security ward days
electrical cord across hallway for O_z machine for patient on 1:1 was hazardous

Hanging Risks
Supports from air circulator in Dayroom
Bedroom door lock switch
Smoking porch
Back stairway

B2

More hospital-like environment than B1

Lunch — patients' food comes on individual trays
staff supervising meals

Hallway — cabinet for patients' toileting – one cubby per patient
activity schedule posted

Dayroom — TV on, room empty
call button – staff showed up in 30-40 seconds

Bedroom — a couple of patient's each had a bureau

Smoking porch – like B1

Bathroom — good efforts to minimize hanging risks

Seclusion Room – DOOR OPEN
(see discussion under B2)

Restraint – use bed on wheels, bed itself is hanging risk, cannot be attached to floor

Hanging Risks
Exposed pipes/sprinklers on porch
Bathroom sink faucets
Bathroom handicap chair in shower
Back stairwell (used by patients)
Loud Speakers (weight tolerance?)

Brooks Rehab

More pleasant environment team B1
Bedroom – mostly doubles, dressers in rooms, hang-proof hooks
Bathroom with single toilet and handicap shower; another single bathroom
Closet in hallway with patients' toiletries – must lock up many items, even Johnson's Baby Shampoo!
Dining Room – all dining rooms are on wards
Yard with blind areas but at least two staff and video monitoring

Hanging Risks
- Electrical socket in Dayroom
- Railing in hallway, especially up ramp in blind area
- Fire hose outlet in blind hallway
- Door handle in blind hallway to outside courtyard